

ADDITIONAL CONTRIBUTIONS TAX-SHELTERED (ACTS) PROGRAM
CARRIER ELECTION AND ALLOCATIONName _____
LAST FIRST MIDDLE INITIAL

Social Security No. _____ Membership No. (IF APPLICABLE) _____

Retirement System (IF APPLICABLE) ☐ PERS ☐ TPAF ☐ PFRSAddress _____
STREET OR RD# APARTMENT NO.

CITY STATE ZIP

Daytime Telephone No. (_____) _____

AUTHORIZED INVESTMENT CARRIERS

Select any number of investment carriers and allocate the percentage of your contributions to each one, totaling 100%. Percentages must be whole numbers. *YOU MUST ESTABLISH A VALID ACCOUNT DIRECTLY WITH THE CARRIER(S) YOU SELECT BEFORE COMPLETING THIS FORM.* Only two changes are allowed in any calendar year.

Check One: ☐ Initial Election ☐ Subsequent Election

	CARRIER ACCOUNT NO.	PERCENTAGE
<input type="checkbox"/> ING Financial Advisers, L.L.C.	_____	_____ %
<input type="checkbox"/> Lincoln Financial Group	_____	_____ %
<input type="checkbox"/> MetLife Resources	_____	_____ %
<input type="checkbox"/> TIAA-CREF	_____	_____ %
<input type="checkbox"/> Travelers (CitiStreet)	_____	_____ %
<input type="checkbox"/> VALIC	_____	_____ %
		100%

I elect to allocate my total employee tax sheltered contributions as indicated above. This allocation becomes effective within 45 days of receipt of a properly completed form. I have read and understand the information on the back of this application.

Employee Signature _____ Date _____

EMPLOYER SECTION

Name of Employing Agency _____ Payroll No. _____

Address of Employing Agency _____

Certifying Officer Signature _____ Title _____

Telephone No. _____ Date _____

Mail completed form to: **Division of Pensions & Benefits, ACTS Program, PO Box 295, Trenton, NJ 08625-0295****FOR DIVISION USE ONLY****SALARY REDUCTION AGREEMENT - CONFIRMATION OF RECEIPT BY DIVISION OF PENSIONS AND BENEFITS**

Effective Date _____ Authorized Signature _____ Date _____

ADDITIONAL CONTRIBUTIONS TAX-SHELTERED (ACTS) PROGRAM

CARRIER ELECTION AND ALLOCATION

GENERAL INFORMATION

Employees of county colleges, state universities and colleges, the Commission on Higher Education, the Department of Education, and the Office of Student Assistance can participate in the Additional Contributions Tax-Sheltered (ACTS) Program. ABP members have the option to select the same individual carriers through the regular Alternate Benefit Program.

A Carrier Election and Allocation Form must be filed to identify the investment carrier(s) with which you want your contributions invested. If you are a new participant, this form must be accompanied by the Salary Reduction Agreement form.

INSTRUCTIONS FOR APPLICANTS:

Please read all information carefully when completing this form. Where applicable, indicate your name, mailing address, social security number, and telephone number where you may be reached during daytime working hours. If you are a member of a state-administered retirement system, check the name of the system and provide your membership number.

To authorize any investment carrier(s), indicate in the relevant box if your request is an initial or a subsequent request. A SUBSEQUENT REQUEST WILL REPLACE ALL PREVIOUS SELECTIONS. Place a mark in the box to the left of the name of the carrier(s) you have selected and provide your account number assigned with that carrier. Enter the percent of the reduction that you want allocated to any carrier(s). Percentages must be in whole numbers and totals must equal 100%.

Sign and date the form and have your certifying officer complete the employer information. A copy will be returned to you after confirmation of receipt indicating the date your reduction will take effect.

Refer to the carrier comparison guide for information on individual carriers. It is your responsibility to complete the necessary forms to establish a valid account with the carrier(s) you select for your investments. If you fail to establish an account with the carrier(s), you may lose earnings from your contributions. Additionally, the carrier(s) will return your contributions to the Division of Pensions and Benefits and your participation will be delayed.

INSTRUCTIONS FOR EMPLOYERS

Please enter the name, address and payroll number of your agency. The designated certifying officer must sign the form indicating his/her title, telephone number, and the date. Upon completion, return this form to:

**DIVISION OF PENSIONS AND BENEFITS
ACTS PROGRAM
PO BOX 295
TRENTON, NJ 08625-0295**